A7/B7: HOME VISITING COLLABORATIVE IMPROVEMENT AND INNOVATION NETWORK (HV COIIN)
Process and Progress

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Tuesday, December 8, 2015
These presenter have nothing to disclose.

Objectives

• Describe the research-informed technical content framing the project
• Illustrate how rapid-cycle tests of change are leading to improvement across targeted outcomes
• Identify ways in which the project provides a framework for state-level and local-level improvement in policy and practice
Project Partners

A 3-Year Cooperative Agreement between The Maternal and Child Health Bureau's (MCHB) Division of Home Visiting and Early Childhood Systems and Education Development Center, Inc.

Start Up: September, 2013-May, 2014
Phase I: May 2014 – August, 2015 (15 months)
Phase II: September, 2015- July, 2016 (11 months)

The Federal Home Visiting Program

Carlos Cano, MD, MPM
Senior Advisor on Quality Improvement
Health Resources and Services Administration
U.S. Department of Health and Human Services
The Federal Home Visiting Program

- Section 2951 of the Affordable Care Act of 2010 (P.L. 111-148)
- Amends Title V of the Social Security Act to add Section 511: Maternal, Infant, and Early Childhood Home Visiting Programs (MIECHV)
- $1.5 billion over 5 years
  - Sustainable Growth Rate (Doc Fix)
    - $100M FY2010
    - $250M FY2011
    - $350M FY2012
    - $400M FY2013
    - $400M FY2014

The Federal Home Visiting Program

Tiered-evidence grant design
- Focuses grant dollars on approaches backed by strong evidence...evidenced-based practices
- Encourages innovation so new & effective approaches are discovered
- Examples:
  - The Home Visiting Program
  - Teen Pregnancy Prevention
  - Investing in Innovation (i3)
  - Workforce Innovation Fund
  - Social Innovation Fund
The Federal Home Visiting Program

An evidence-based, place-based strategy

- Programs in all 50 states, DC and five territories (767 counties)
- Services provided in over 700 communities - urban, rural and frontier (2014)
- Nearly 1.4M home visits over first three years of program
- 115,500 parents and children served in 2014

The Federal Home Visiting Program

- Supports Families
  - Evidence-based parent support services
  - Partnership between parents and home visitors
  - Ongoing visits and dialogue around family needs
- Voluntary
  - Families empowered w/ knowledge on health and parenting
- Evidence-based
  - Built on four decades of rigorous research
    - Evidence-based HV models
  - Includes a national randomized controlled evaluation
  - Launched first HV improvement collaborative: HV CoIIN
The Federal Home Visiting Program

**Effective**
- HV prevents child maltreatment, encourages positive parenting and promotes child development
- Reduction of school dropout, teen pregnancy and crime
- Every $1.00 invested, yields up to $9.50 ROI to society

**Locally designed and run**
- States have flexibility to tailor programs to fit needs of different communities
- States can choose from 14 Evidence-based HV models
- Programs run by local organizations w/ support from states and HV model developers

**Growth and Reach**

**Growth in the Number of Participants**

- 2012: 34,180
- 2013: 75,970
- 2014: 115,545
Who are the families we serve?

- 27% of newly enrolled households included pregnant teens
- 20% reported a history of child maltreatment
- 4/5 of participating families had household incomes at or below the 100% of federal poverty line ($23,850 for a family of four)
- Almost half were at or below 50% of FPL
- 1/3 of adult participants had less than a high school education
- 2/3 of program participants belonged to a racial/ethnic minority

Child Development Trajectories

Adapted from N. Halfon, 2015
Purposes of the HV CoIIN

- Disseminate practices known to work
- Innovate
- Achieve results faster
- Build leaders of QI - Sustainability
- Demonstrate effectiveness of home visiting in large scale implementation

The Breakthrough Series as the HV CoIIN Framework

LS1: Learning Session
AP: Action Period
P-D-S-A: Plan-Do-Study-Act

Supports:
- Email
- Visits
- Phone Conferences
- Monthly Team Reports
- Assessment

www.IHI.org
**Participants**

12 states & tribes
30 implementing agencies, using 5 evidence-based models
36 quality improvement teams
3500 families

**HV CoILN Structure:**
Management Team & Faculty

- **Sponsor:** David Willis, HRSA
- **Project Officer:** Carlos Cano, HRSA
- **Project Director:** Mary MacKain
- **Improvement Advisor:** MC Arbour
- **Innovation Consultant:** Peter Gloor
- **Evaluator:** Deborah Perry
- **Breastfeeding:** Joanne Martin, Elaine Fitzgerald, Sally Fogerty
- **Depression:** Darius Tandon, N. Topping-Tailby, Linda Beeber
- **Development:** Paul Dworkin
- **Family Engagement:** Brenda Jones, Harden, Jon Korfmarher, Deborah Daro
- **Leadership Team:** Project officer, Project Director, Improvement Advisor, Innovation consultant, Faculty chair(s) and External Evaluator
HV CoIIN Structure: 12 States & Tribes

Sponsor, David Willis, HRSA
*Project Officer, Carlos Cano, HRSA
Project Director, Mary Mackrain
EDC Staff

*Improvement Advisor
- MC Arbour
*Innovation Consultant
- Peter Gloor
*Evaluator
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Development
- Paul Dworkin
- Brenda Jones
- Harden

Family Engagement
- Jon Korfmacher
- Deborah Daro

Arkansas
Florida
Georgia
Michigan

New Jersey
Ohio
Pennsylvania
Rhode Island
S. Carolina
Virginia
White Earth
Wisconsin

State/Tribal Leaders

11 LIA Teams
12 LIA Teams
12 LIA Teams
35 LIA Teams

EDC Staff
Starting Knowledge of QI

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<tr>
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<th>Baseline Survey (1-10)</th>
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<td>Driver Diagrams</td>
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Group Share

- What tools have others used to assess baseline knowledge of QI team members?

- What implications has knowledge level posed for your work?
We developed a HV CoIIIN “Playbook”

Helping Teams with “Why, What and “How”

Charter

- The Problem statement
- Gap between science and practice
- Mission statement
- Specific aims
- Expectations
  - CoIIIN
  - State / grantees
  - Front-line teams (LIAs)
- Team’s commitment
PD3 - Standardize Processes for Referral Treatment and Follow up

1. Establish and maintain relationship with community service provider (e.g., MOU/contract with mental health service provider for priority services)  
2. Crisis response protocol  
3. Protocol for referral and linkage to service for mothers screening positive (internal and/or external services)  
4. Early childhood mental health provider integrated into program to provide group treatment, case consultation, joint visits, etc.  
5. In-house evidence-based treatment (Mothers and Babies, Moving Beyond Depression) delivers by home visitors or behavioral health staff/consultants  
6. Home visitor delivered, relationship based support (prevention) to families for maternal depression (e.g., motivational interviewing to discuss maternal depression, active listening, shorter and more frequent visits, etc.)
Shared Measures Developed

1. **Intentional Support and Technical Assistance Provided**

   - **Monthly Topic Calls**
     - State Leaders and QI Teams come together each month with faculty 
       & staff via webinar to:
       - Learn Content from expert faculty
       - Share PDSA Testing Plans & Results
       - Receive QI Teaching (ex. How to scale a test, Pareto charts, etc.)

   - **Learning Sessions**
     - In-person Learning Sessions provide an intensive working meeting for learning, sharing of ideas and planning for the next action period.

   - **Coaching**
     - Regular coaching is available for QI teams and state leads from the Improvement Advisor, faculty and Project Director

   - **Website/Listserves**
     - The internal portal of the HV CoIN website provides real-time HV CoIN resources, peer QISAs, an active Q & A forum and monthly data. Additionally, each topic area has an e-mail list serve that can be used to share resources questions and ideas with faculty, peers, state leads and staff.
Group Share

- What resources have you found helpful when kicking off a collaborative?

HOME VISITING COLLABORATIVE IMPROVEMENT AND INNOVATION NETWORK (HV COIIN)

Phase I
Process and Progress

What did we aim to do?
What did teams do?
What have we achieved?
What have we learned?
Every system is designed perfectly to achieve exactly the results it gets. *Paul Batalden, MD*
What are the gaps in breastfeeding?

- Many initiate, few sustain
- Families in MIECHV programs even lower than national average
- Varies considerably by state and by family background

Key Driver Diagram: HV CollIN Breastfeeding Extension

SMART Aim
To increase by 20% from baseline the % of women exclusively breastfeeding at 3 months & 6 months

Increase the percent of exclusive breastfeeding at 3 and 6 months
Breastfeeding Key Driver Diagram

Primary Drivers

PD1. Standardize internal (agency) policies and practices to support breastfeeding
- Breastfeeding policy, protocol and print resources for the delivery of breastfeeding support promptly and promptly
- Standardized professional development for home visitors in breastfeeding policies and protocols
- Home visitors with lactation and breastfeeding knowledge & competencies
- Regular professional development for home visitors on infant feeding practices that support a culturally sensitive, family-centered, relationship-based approach
- Establish cooperative relationships with key community breastfeeding partners (WIC, La Leche League, etc.)
- Establish relationships with breastfeeding support groups
- Clear loop of communication for referral, access and engagement in breastfeeding supports and services
- Mothers informed of the benefits of breastfeeding (paying special attention to debunk myths)
- All home visitors empowered to meet individual BF goals
- All home visitors engage in regular client-led conversation regarding breastfeeding
- Use of best practices/evidence-informed strategies to enhance mother-baby breastfeeding practices

PD2. Build capacity of and support for home visitors to address breastfeeding in the target population
- Regularly access data on quality improvement
- Regular access to performance data for quality improvement
- Timely and effective supervisory support
- Establish cooperative relationships with key community breastfeeding partners (WIC, La Leche League, etc.)
- Establish relationships with breastfeeding support groups
- Clean loop of communication for referral, access and engagement in breastfeeding supports and services
- Mothers informed of the benefits of breastfeeding (paying special attention to debunk myths)
- All home visitors empowered to meet individual BF goals
- All home visitors engage in regular client-led conversation regarding breastfeeding
- Use of best practices/evidence-informed strategies to enhance mother-baby breastfeeding practices

PD3. Create strong community linkages to breastfeeding support systems
- Clear loop of communication for referral, access and engagement in breastfeeding supports and services
- Mothers informed of the benefits of breastfeeding (paying special attention to debunk myths)
- All home visitors empowered to meet individual BF goals
- All home visitors engage in regular client-led conversation regarding breastfeeding
- Use of best practices/evidence-informed strategies to enhance mother-baby breastfeeding practices

PD4. Family Engagement
- Mothers informed of the benefits of breastfeeding (paying special attention to debunk myths)
- All home visitors empowered to meet individual BF goals
- All home visitors engage in regular client-led conversation regarding breastfeeding
- Use of best practices/evidence-informed strategies to enhance mother-baby breastfeeding practices

Secondary Drivers

PD1. Standardize internal (agency) policies and practices to support breastfeeding
- Breastfeeding policy, protocol and print resources for the delivery of breastfeeding support promptly and promptly
- Standardized professional development for home visitors in breastfeeding policies and protocols
- Home visitors with lactation and breastfeeding knowledge & competencies
- Regular professional development for home visitors on infant feeding practices that support a culturally sensitive, family-centered, relationship-based approach
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- Use of best practices/evidence-informed strategies to enhance mother-baby breastfeeding practices

Specific Ideas to Test or Change Concepts

C1. Protocol for IV delivery of BF support (e.g., Boston Infant Feeding Toolkit)
C2. Protocols for documenting communication and referral of families to key community partners
C3. Initial and refresher training for HVs on agency policies and protocols
C4. Print materials align with CDC Guidelines
C5. Comprehension for HVs to adequately address breastfeeding with families
C6. Requirement and provision of training for home visitors consistent with United States Breastfeeding Committee guidelines
C7. Data on measures provided regularly to home visitors to aid in quality improvement
C8. Regular Reflective supervision
C9. Memo on understanding with Key Community Partners (e.g., WIC)
C10. Current resource lists of peer support groups & Baby Friendly Hospital
C11. Establish breastfeeding teams
C12. Protocol for warm hand off and follow up
C13. Use of Boston Healthy Start Infant Feeding Toolkit
C14. Use of Boston Healthy Start Infant Feeding Toolkit
C15. Identifying & strengthening formal and informal supports (partner, primary care, other family members, etc.)
C16. Establish cooperative relationships with key community breastfeeding partners (WIC, La Leche League, etc.)
C17. Establish relationships with breastfeeding support groups
C18. Clear loop of communication for referral, access and engagement in breastfeeding supports and services
C19. Mothers informed of the benefits of breastfeeding (paying special attention to debunk myths)
C20. All home visitors empowered to meet individual BF goals
C21. All home visitors engage in regular client-led conversation regarding breastfeeding
C22. Use of best practices/evidence-informed strategies to enhance mother-baby breastfeeding practices

Calhoun County NFP PDSA

PDSA PD1: Standardize internal policies & practices to support breastfeeding

Goal: To complete 2 joint home visit with the client, home visitor & lactation specialist: 1 within 1 month of the estimated due date and another within 3 days of delivery

Model for Improvement

Act | Plan | Study

By Jan 2015, all prenatal clients will receive a joint home visit from the home visitor and BF support nurse within 1 month of EDD and within 3 days of delivery

% of clients receiving both joint HVs

Supervisors will identify eligible clients and develop protocol and data tracking sheet. Home visitor will coordinate and complete visits
Calhoun County NFP PDSA

PDSA PD1: Standardize internal policies & practices to support breastfeeding

Goal: To complete 2 joint home visit with the client, home visitor & lactation specialist: 1 within 1 month of the estimated due date and another within 3 days of delivery

Cycle 1: Supervisor identifies clients due to deliver within 1 month. HV plans joint visit with BF support nurse

Cycle 2: new documentation forms make content, purpose & results of pre- & postpartum BF visits clear

Cycle 3: adaptations to prenatal & postnatal forms introduced by BF support nurse, who leads the prenatal visit & planning of postpartum visit

Cycle 4: clients prefer to see only their HV during post-partum visit, protocol adapted

Calhoun County NFP PDSA

Study

Goal: To complete 2 joint home visit with the client, home visitor & lactation specialist: 1 within 1 month of the estimated due date and another within 3 days of delivery

Calhoun County- Percent of Women Who Initiate Breastfeeding

PDSA for joint visits
What are our achievements in breastfeeding?

1. Improvement in home visitors prepared to provide breastfeeding support.
What are our achievements in breastfeeding?

2. Improvement in initiation rates at some participating sites
What have we learned in breastfeeding?

1. Questions remain about how to identify women who need more support than a home visitor usually provides and get them that support (community linkages)

What have we learned in breastfeeding?

2. Making progress toward our overall goal requires:
   • more testing and attention to the ‘critical periods’ in breastfeeding decision-making
   • measure earlier in the post-partum period when most women stop breastfeeding
Developmental Surveillance and Screening

What are the gaps in developmental promotion, early detection and intervention?

- Over half of children with developmental concerns not caught until school enrollment
- Of 10-13% of children with developmental delays, only 2-3% receive appropriate services
- Varies considerably by state and by family background

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Key Driver Diagram: HV CoLlN Developmental Screening

SMART Aim
Increase by 25% the % of children with developmental or behavioral concerns receiving assessment or intervention in a timely manner

Children who need it receive developmental services

Theory of Change For Developmental Promotion, Early Detection and Intervention

Primary Drivers
Secondary Drivers

SMART Aim
Increase by 25% the % of children with developmental or behavioral concerns receiving assessment or intervention in a timely manner

PD1. Reliable and effective systems for surveillance & screening
Identification of appropriate developmental and behavioral screening instruments, optical screening

PD2. Reliable and effective systems for referral & follow-up
Reach and sustaining community partners and resources

PD3. Home visits supported to address developmental in the target population
Home visits with knowledge of infant’s understanding on the child development system & processes

PD4. Engage families in promotion of healthy development
Families’ effect on development supported & maximized through education, strengthening of protective factors, etc.

PD5. Advance technology for early detection
How technology is advancing in the field of developmental screening

PD6. Referral and information sharing
How referrals are shared and information is shared

Specific Ideas to Test or Change Concepts

1. Development & Accountability: Balancing short-term & long-term goals
2. Policy & Advocacy: Shaping policies & advocating for change
3. Communication & Collaboration: Strengthening partnerships & collaboration
4. Family Engagement: Involving families in the process
5. Economic & Fiscal: Understanding the economic implications

Incorporate the best practice of eliciting at every home visit parental concerns about their child’s development, learning or behavior.

% of home visits where parental concerns elicited

Add a label to the home visit forms that says ‘Were parent’s concerns about their child’s learning, development, or behavior elicited? Yes No’

Philadelphia NFP PDSA
PDSA PD1: Reliable & effective systems for screening & surveillance

**Goal:** To elicit parent concerns about development, learning and behavior at every home visit

**Cycle 1:** Add a label to the home visit forms that says "Were parent’s concerns about their child’s learning, development, or behavior elicited? Yes No"

Collect data on nurses’ monthly summary sheets: add place to track the number of visits this question was asked
Overall the nurses were open to this method and found it helpful to include during their visits.

Some nurses were getting confused about the wording of the question.

- Some used the sticker / tracking column to ask the question ONLY if the parent initiated a conversation about a concern, which was not what we were trying to accomplish.
- They said rephrasing the question would help.

Goal: To elicit parent concerns about development, learning and behavior at every home visit

Cycle 1: Add a label to the home visit forms that says "Were parent’s concerns about their child’s learning, development, or behavior elicited? Yes No".

Collect data on nurses’ monthly summary sheets: add place to track the number of visits this question was asked.

Cycle 2: Rephrase the question and put a new label on the HV forms until we can have them reprinted again.

Clarify that this question should be asked and answered in every home visit with every family.
Philadelphia NFP PDSA
Study: Cycle 2

Goal: To elicit parent concerns about development, learning and behavior at every home visit

- drop on the run chart (90% to 50%) reflects nurses understanding improved after we clarifying that this should be asked in ALL visits
- all staff report understanding what they are reporting better
- we’re confident our data is correct, we can see the areas for improvement and where in the process nurses are getting stuck

What we like about PDSAs

- It’s ok to fail!
- Becomes a learning process
- Has created a culture of quality improvement
  - “staff view challenges as an opportunity to do a PDSA cycle”
- Forces us to evaluate our processes and allows us to find areas for improvement

Challenges

- Learning curve of how quick the cycles can be
- Communication: Reminding staff when we are starting a new process
HV CoILN Bulletin Board

Primary Drivers

PD4. Engage Families in Promotion of Healthy Development

Secondary Drivers

Families’ direct impact on development supported & maximized (through stimulation, strengthening of protective factors, etc)

HV engages family-led conversation regarding development at every home visit

Referrals & linkages HV recommends are acceptable to family (geographically, culturally appropriate)

C3. HV seek feedback from parents on use of referred services

Developmental Screening Key Driver Diagram

C1. Anticipatory guidance & education to families about development based on screening process

C2. Protocols for addressing parent concern with home visiting activities

C3. HV seek feedback from parents on use of referred services

Ages and Stages Questionnaire (ASQ-3)

My Baby Name: __________________________

Month: __________________________

And let’s have fun working on: __________________________

Date: __________________________

Marion Adolescent Parenting Program, 2015

Marion Adolescent Parenting Program

Ohio
What are our achievements in developmental promotion, early detection and intervention?

We are engaging families in developmental promotion

1. In 2000 home visits each month, families are being asked if they have concerns about their child’s development, behavior or learning.

2. Home visitors provided individualized developmental promotion to 85% of children with concerns.

What have we learned in developmental promotion, early detection and intervention?

1. Challenges remain to communication and coordination with community services and Part B/C early intervention services to support children’s development (community linkages)
   - resources in community
   - criteria for referral
   - systems for knowing what happens with referrals
What are the gaps in maternal depression?

- **Many affected**
  - 40-60% of HV mothers experience elevated symptoms; 10-15% have major depression

- **Many missed**
  - Only 65% of mothers in HV are screened for depression

- **Many unhelped**
  - Only 57% of mothers with elevated symptoms referred for services

Key Driver Diagram: HV CollIN Maternal Depression

**SMART Aim**
85% of women who screen positive for depression and access services will report improvement in symptoms

Women accessing services for depression get better
**Key Driver Diagram: HV CoIIN Maternal Depression Screening, 5-8-14**

**Primary Drivers**
- Standardize processes for maternal depression screening and response
- Capacity of and support for HVs to address maternal depression in target population
- Standardize processes for referral, treatment & follow-up

**Secondary Drivers**
- Identification and correct use of appropriate screening instrument
- Periodicity to capture vulnerable windows
- Timely, specific & sensitive communication of results (positive and negative) to families & HVs if outside assessor
- Response protocol for urgent and non-urgent care
- Professional Development in HV delivered interventions
- Timely and effective supervisory supports
- Identification of locally-available evidence-based mental health services and interventions for crisis and ongoing treatment
- Development of internal services for treatment
- Establish referral and linkage process to mental health resources (internal and external)
- Standards process for home visitor to complete a referral and follow up
- Standardized process in place for Crisis Response
- Training for home visitors on relationship-based practice to build increased sensitivity to families varying capacity to engage around MH issues

**Family Engagement**
- Understanding families' capacity to address mental health issues as demonstrated by continued enrollment in the HV program

**Smart Aim**
85% of women who screen positive for depression and access services will report improvement in symptoms

**Specific Ideas to Test or Change Concepts**
- Protocol for screening standards to include reliable, valid tools & periodicity
- Initial training of assessors on tool use and protocols
- Periodic refresher training
- Protocols for assessing parent satisfaction
- Training / education of HV (how to screen, coach, motivational interviewing, provide HV in-house intervention)
- Reflective supervision: encourage home visitors to raise problems, emphasis on stigma, attention to home visitor's mental health
- Home visitor has access to own data
- Support for HV’s on protocol responses
- Ticklers / reminder system for re-screens
- Simple and timely access to screening tools
- Establish and maintain relationship with community service providers (e.g. MOU's)
- Early childhood mental health consultant integrated into program
- In-House EBP-Mother’s and Babies Course, IH-CBT
- Protocol for referral and linkage to services for mothers screening positive
- Identifying families' capacity to address mental health issues as demonstrated by continued enrollment in the HV program

**Stark County HFA**

**PDSA PD2: Capacity of and support for HVs to address maternal depression in target population**

- By Jan 2015, all home visitors will use Motivational Interviewing to talk with mothers about depression, and will increase referrals to services by 25%

- % of visits in which MI techniques are used

- Home visitors will be trained in MI, will practice 1 new MI technique per week on a topic other than maternal depression, supervisors will monitor in weekly meetings

**Model for Improvement**
- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

---

Lange, et al. (2006) p96
**Stark County HFA PDSA**

**Plan & Do**

**Cycle 1:** all home visitors will use 1 MI technique in 50% of visits & feel comfortable with it. Data tracking form introduced

**Cycle 2:** Home visitors use 2 MI techniques in 60% of visits. Data tracking form revised

**Cycle 3:** Home visitors use 3 MI techniques in 70% of visits

**Cycle 4:** Home visitors use 4 MI techniques in 80% of visits

**Cycle 5:** Home visitors use 5 MI techniques in 90% of visits

**Cycle 6-10:** Home visitors apply MI techniques to depression with mothers w +screen who refused services

**Stark County HFA PDSA**

**Study**

Home visitors used MI techniques more frequently than predicted
- Week 1: 93% of visits
- Week 2: 93% of visits
- Week 3: 96% of visits
- Week 4: 98% of visits
- Week 5: 100% of visits

![Graph showing Stark County: % of women with a +MD screen referred to services with 1+ service contact]
What are our achievements in maternal depression?

1. Met goal of screening 85% of women at appropriate intervals

2. Improvement in % of women referred to services for a positive screen who had 1 or more evidence-based service contact

3. Measurement of symptoms over time established
What have we learned in maternal depression?

1. Need for capacity-building for home visitors to deliver evidence-based mental health services

2. Ongoing monitoring, rescreening and conversation using motivational interviewing and other tools can help a home visitor and client

What are the gaps in family engagement?

**Enrollment**
- As many as 50% of families referred to home visiting can never be reached
- 20-100% receive a 1st home visit

**Retention**
- 47% of families complete shorter term programs (<6 months)
- 58-73% of families in multi-year programs complete 1 year

What are our achievements in family engagement?

1. Individual LIAs showed improvement in
   • % families referred to HV program this month who received first face to face contact within 10 days
   • % of expected in-person contacts that were completed
   • 3 and 6 month retention

What have we learned in family engagement?

1. There is a lot of interest in working on family engagement that would be better served by splitting it off into its own topic area

2. Treating families that are not on the typical visit schedule* separately will help us learn more about the typical processes
   *i.e. creative outreach, level X, alternate visit schedule

3. Enrollment processes are complex and vary by state – additional measures are needed
Reflecting on Phase 1

Purpose

• Close the Gap between what we know works and usual practice
• Achieve results faster
• Build leaders of Quality Improvement – Sustainability
• Demonstrate effectiveness of home visiting in large scale implementation

Reflections from Phase 1 of the HV CoIIN

Outstanding Participation

• 81% participation on monthly topic calls
• 87% PDSA submission each month
  more than 700 PDSAs
• 92% data reports submitted each month
  • Data submitted is of high quality (>90% complete)
Goals in Knowledge

Baseline Survey
Follow-up Survey

Purpose of HV CoIIN: Build leaders of Quality Improvement – Sustainability

Lessons from Phase 1 of the HV CoIIN

CQI has strong component of data use that can feel burdensome to participants initially. Over time this usually changes because the data is useful

1) it’s directly linked to your processes
2) it reveals the fruits of your efforts and makes it possible to recognize and celebrate good work
3) we look at the data together and across the collaborative every month, and it directs us to learn from some sites and reach out to others

It’s important to provide a lot of experiential, hands-on practice in order to help teams get comfortable with data.
Lessons from Phase 1 of the HV CoIIN

Home visiting interventions that include CQI put parents on improvement teams as equal co-creators of the intervention, with powerful results

HV CoIIN Pinellas works with substance abusing parents did a PDSA to increase family engagement by celebrating the participants who completed 8 foundational visits

  Parent: it was the only thing she’d been celebrated for since graduating from middle school

HV CoIIN NFP site: parent graduate had an idea for increasing engagement by starting a parents’ group. She ran her own PDSAs creating a parents’ group that intentionally includes fathers

Lessons from Phase 1 of the HV CoIIN

CQI transforms implementation teams into protagonists

“We used to wait to have the model tell us what to do. Now we have realized: what a minute! We can do something about this. We look at our data and we ask ourselves what we want to accomplish and how we can improve.”

Jennifer Haberman-Boleyn, Marion Adolescent Parenting Program

All teach, all learn
What do participants say?

Participants have learned a lot.
“One of our biggest successes was growing our knowledge of PDSA cycles and the implementation of CQI in our program.”

Participants are achieving the outcomes they aim for.
“We standardized our evaluation and referral process, and there is so much growth in my skills to support and discuss developmental concerns with clients”

Participants anticipate the improvements they’re seeing will be sustained.
“Almost all of the testing we did has moved to implementation—so a great deal of the work will be sustained.”

What’s next?
Phase 2 HV CoILN 2015-2016

- 80% of participating LIAs chose to continue
- 13 new LIAs and 1 new state enroll
- Updated Key Driver Diagrams, Measures & Change Packages
  - Incorporated learning from Phase 1
  - Integrated sample PDSAs for new teams to ‘steal shamelessly’
- Coach in teams so everyone learns
- Enhanced support to and collaboration from Grantee leaders and Model Developers to build human capacity for spread
- HV CoILN work to assist HRSA with the redesign of a national performance measurement system for HV
- Share resources and lessons learned with others
For More Information…

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Group Share

- What successes have you had with supporting teams in their QI work?
Group Share

- How do you work to maintain participant will?
- How have you successfully celebrated teams work?